

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

13686

Registration District No.

Primary Registration District No.

Registrar's No.

3888

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 mos 17 days  
(Specify whether  
In this community 5 years  
years, months or days)

8. (a) PRINT FULL NAME Robert Anderson

3. (b) If veteran, name war Unk. 3. (c) Social Security No. Unk.

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Unk.  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
About 35 hr. min.

9. Birthplace Louisiana  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

12. Name Frank Anderson

13. Birthplace Louisiana  
(City, town, or county) (State or foreign country)

14. Maiden name Unk.

15. Birthplace Unk.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Phorence A. Spotts

(b) Address 2601 N. Whittier

17. (a) (Burial, cremation, or removal) Washington (b) Date thereof 4/25/40  
(Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. R. Ritten

(b) Address 3500 Rutger

19. (a) APR 20 1940 (b) J. P. Ritten  
(Date received local) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2628 Lawton Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 19  
year 1940 hour 4 minute 55 P. M.

21. I hereby certify that I attended the deceased from 11-2-, 1939, to 4-19-, 1940;  
that I last saw him alive on 4-19-, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration Approx 9 mos

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature M. W. Allen (M, D. or other) 4-22-1940  
Address 2601 N. Whittier St. Date signed \_\_\_\_\_

(Licensed Embalmer's Statement on Reverse Side)

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**